

Complete Summary

GUIDELINE TITLE

Special treatment issues in lung cancer: ACCP evidence-based clinical practice guidelines. (2nd Edition)

BIBLIOGRAPHIC SOURCE(S)

Shen KR, Meyers BF, Larner JM, Jones DR, American College of Chest Physicians. Special treatment issues in lung cancer: ACCP evidence-based clinical practice guidelines (2nd edition). Chest 2007 Sep;132(3 Suppl):290S-305S. [79 references] [PubMed](#)

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Detterbeck FC, Jones DR, Kernstine KH, Naunheim KS. Presentations of lung cancer with special treatment considerations. Chest 2003 Jan;123(1 Suppl):244S-58S.

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SCOPE

DISEASE/CONDITION(S)

Particular forms of non-small cell lung cancer that require special considerations. This includes:

- Pancoast tumors
- T4N0,1M0 tumors
- Satellite nodules in the same lobe
- Synchronous and metachronous multiple primary lung cancers (MPLCs)

- Solitary brain and adrenal metastases
- Chest wall involvement

GUIDELINE CATEGORY

Diagnosis
Management
Treatment

CLINICAL SPECIALTY

Family Practice
Oncology
Pulmonary Medicine
Radiation Oncology
Thoracic Surgery

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Care Providers
Nurses
Patients
Physicians
Psychologists/Non-physician Behavioral Health Clinicians
Social Workers

GUIDELINE OBJECTIVE(S)

To provide clinically relevant, evidence-based guidelines for lung cancers with special treatment considerations

TARGET POPULATION

Patients with particular forms of non-small cell lung cancers that require special considerations. This includes Pancoast tumors, T4N0, 1M0 tumors, satellite nodules in the same lobe, synchronous and metachronous multiple primary lung cancers (MPLCs), solitary brain and adrenal metastases, and chest wall involvement.

INTERVENTIONS AND PRACTICES CONSIDERED

Pancoast Tumors

1. Tissue diagnosis prior to therapy
2. Evaluation for lung resection
 - Magnetic resonance imaging (MRI) of thoracic inlet and brachial plexus
 - Invasive mediastinal staging and extrathoracic imaging (head computed tomography [CT]/MRI plus either whole-body positron emission tomography [PET] or abdominal CT plus bone scan)

3. Concurrent chemoradiotherapy and radiotherapy
4. Complete resection (lobectomy including removal of involved chest wall structures)
5. Palliative radiotherapy

T4N0, 1M0 Tumors

1. Invasive mediastinal staging and extrathoracic imaging (head CT/MRI plus either whole-body PET or abdominal CT plus bone scan)
2. Resection should be undertaken only at a specialized center

Satellite Nodules and MPLCs

Satellite Nodules in the Same Lobe

1. Classify according to clinical presentation and as dictated by the primary lung cancer
2. Resection via a lobectomy

Synchronous Second Primary Lung Cancer

1. Invasive mediastinal staging and extrathoracic imaging (head CT/MRI plus either whole-body PET or abdominal CT plus bone scan)
2. Investigation for extrathoracic primary cancer
3. Resection of each lesion

Metachronous Second Primary Lung Cancer

Invasive mediastinal staging and extrathoracic imaging (head CT/MRI plus either whole-body PET or abdominal CT plus bone scan)

Isolated Brain Metastasis

1. Invasive mediastinal staging and extrathoracic imaging (head CT/MRI plus either whole-body PET or abdominal CT plus bone scan)
2. Resection or radiosurgical ablation of an isolated brain metastasis

Therapies Considered but Evidence is Conflicting and/or Insufficient

1. Adjuvant whole-brain radiotherapy (WBRT)
2. Adjuvant chemotherapy

Isolated Adrenal Metastasis

1. Invasive mediastinal staging and extrathoracic imaging (head CT/MRI plus either whole-body PET or abdominal CT plus bone scan)
2. Resection of the primary tumor
3. Resection of an isolated adrenal metastasis

Tumors That Invade the Chest Wall

1. Invasive mediastinal staging and extrathoracic imaging (head CT/MRI plus either whole-body PET or abdominal CT plus bone scan)
2. Chemoradiotherapy if surgical resection is contraindicated
3. Achieve complete resection if resection is indicated

MAJOR OUTCOMES CONSIDERED

- 5-year survival
- Palliation of pain
- Operative mortality

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Overview

The American College of Chest Physicians (ACCP) chose the Duke University Center for Clinical Health Policy Research to perform formal systematic reviews of the current evidence in the five new non-small cell lung cancer (NSCLC) topic areas, as well as to provide a search for the existing guidelines, systematic reviews, and meta-analyses in all of the topics areas. In addition, the Agency for Healthcare Quality and Research (AHRQ) agreed to fund the BlueCross BlueShield Association Technology Evaluation Center to perform the formal systematic review of literature on small cell lung cancer (SCLC). The Health Outcomes Research Group of the Department of Epidemiology and Biostatistics at Memorial Sloan-Kettering Cancer Center conducted a full-scale review of the literature since the first set of guidelines in the area of screening for lung cancer to assist that particular writing group.

The formal systematic reviews of the five new topic areas were guided by the appropriate chapter editors and their writing committees, in concert with the Executive Committee of the panel.

The two EPC research teams conducted a variety of systematic computerized bibliographic database searches including the following: (1) a search for systematic reviews, guidelines, and meta-analyses published since the last ACCP lung cancer guideline (MEDLINE, The Cochrane Library, National Guidelines Clearinghouse); (2) targeted searches for reviews in each of five selected treatment sections (solitary pulmonary nodules, stage I and II, stage IIIA, stage IIIB, stage IV); these searches, run in OVID version of MEDLINE, were performed in July and August 2005 and were limited to publication years since 1995, English language, and human subjects; and (3) searches related to SCLC are described in the evidence chapter on SCLC. Search terms included the medical subject heading terms lung neoplasms (exploded) and bronchial neoplasms for the lung cancer

concept. Each topic search utilized key words specific to the key questions of interest (complete search strategies are available on request from the authors).

Strategy Specific for Special Treatment Issues in Lung Cancer

A formal meta analysis was not available for any of the particular forms of NSCLC that are the subject of this chapter, and resources did not permit the American College of Chest Physicians (ACCP) to conduct such an analysis independently. Clinical guidelines from other organizations were available only with regard to Pancoast tumors. These involve primarily consensus opinion statements and are discussed in the "Pancoast Tumors" section. The recommendations in this section rely heavily on the data from this review.

For ensuring that these guidelines were supported by the most current data available, publications that were appropriate to the topics covered were obtained by performance of a literature search of the MEDLINE computerized database. When possible, the developers also referenced other consensus opinion statements. The data regarding the approach to these special situations were reviewed, summarized, and used to define management recommendations by the writing committee.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus
Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

High Randomized controlled trials (RCTs) without important limitations or overwhelming evidence from observational studies*

Moderate RCTs with important limitations (inconsistent results, methodologic flaws, indirect, or imprecise) or exceptionally strong evidence from observational studies*

Low or very low Observational studies or case series

*Although the determination of magnitude of the effect based on observational studies is often a matter of judgment, the guideline developers offer the following suggested rule to assist this decision: a large effect would be a relative risk >2 (risk ratio < 0.5) [which would justify moving from weak to moderate], and a very large effect is a relative risk > 5 (risk ratio < 0.2) [which would justify moving from weak to strong]. There is some theoretical justification in the statistical literature for these thresholds (the magnitude of effect that is unlikely or very unlikely to be due to residual confounding after adjusted analysis). However, once the decision is made, authors should be explicit in justifying their decisions.

METHODS USED TO ANALYZE THE EVIDENCE

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Quality of evidence is scored in three categories with high-quality evidence obtained from randomized controlled trials (RCTs) without important methodologic limitations based on the study design, the consistency of the results, and the directness of the evidence. In extraordinary circumstances, significant and consistent evidence from observational studies could also be ranked as high quality. RCTs with important methodologic limitations or flaws, inconsistent results, or indirect or imprecise results would be scored as medium quality, as well as exceptionally strong evidence from observational studies. Other observational studies or case-series data would fall into the low quality of evidence category. It is the interface of the quality of the evidence and the balance of benefits to harms or burdens that determines the strength of the recommendation, with a 1A recommendation being the strongest and 2C the weakest.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus
Informal Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Writing committees studied the evidence and summary tables or reviewed the literature for their assigned topics, developing their arguments for the recommendations and suggested grading of those recommendations that were put forth for early drafts. The Executive Committee of the panel, composed of the Chair, Vice-Chair, methodologist, and both project managers, reviewed drafts of each chapter of the manuscript during the writing process. Sections that were determined to be potentially overlapping were shared among the appropriate chapter editors, and conference calls were organized to coordinate the placement of these sections and to confirm that there would be no conflicting information or recommendations.

A conference of the panel was convened in July 2006, prior to which time all panelists, including representatives from the invited organizations, were requested to review the complete manuscript and identify recommendations for which the proposal, wording, or grading were determined to be controversial or could be interpreted as controversial by others, incorrectly evolved from the evidence, disagreement existed with regard to the proposal or the grading, or required full panel discussion and further review for any reason. When the panelists who were present were not in unanimous agreement with the proposed recommendations or the grading of the recommendations, informal group consensus techniques were employed. After the meeting, a series of conference calls were convened to finish the discussions and finalize the recommendations. There were a few chapters for which there was insufficient time for full dialogue during the meeting; in the interest of ensuring that the recommendations followed

the evidence, the conference calls were necessary. This process ensured the "buy-in" of the panelists and was deemed to be a worthwhile effort.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Grade of Recommendations Scale

Grade	Recommendation
1A	Strong
1B	Strong
1C	Strong
2A	Weak
2B	Weak
2C	Weak

Relationship of Strength of the Supporting Evidence to the Balance of Benefits to Risks and Burdens

Balance of Benefits to Risks and Burdens				
Quality of Evidence	Benefits Outweigh Risks/Burdens	Risks/Burdens Outweigh Benefits	Evenly Balanced	Uncertain
High	1A	1A	2A	
Moderate	1B	1B	2B	
Low or very low	1C	1C	2C	2C

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Following final chapter revisions and incorporation of these ultimate recommendations and grading, a concluding review was conducted by the guideline panel Executive Committee. The guidelines were then submitted for review and approval to the American College of Chest Physicians Health and Science Policy Committee (ACCP HSP) Committee, as well as the Thoracic Oncology Network of the college.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Definitions for the strength of evidence and recommendation grades (1A-2C) follow the recommendations.

Pancoast Tumors

Definition: Lung cancers that occur in the apex of the chest and invade apical chest wall structures are called superior sulcus tumors, or Pancoast tumors.

1. In patients with a Pancoast tumor, it is recommended that a tissue diagnosis be obtained before initiation of therapy. **Grade of recommendation, 1C**
2. In patients who have a Pancoast tumor and are being considered for curative intent surgical resection, an magnetic resonance imaging (MRI), of the thoracic inlet and brachial plexus is recommended to rule out tumor invasion of unresectable vascular structures or the extradural space. **Grade of recommendation, 1C**
3. In patients with a Pancoast tumor involving the subclavian vessels or vertebral column, it is suggested that resection be undertaken only at a specialized center. **Grade of recommendation, 2C**
4. In patients who have a Pancoast tumor and are being considered for curative resection, invasive mediastinal staging and extrathoracic imaging (head computed tomography [CT]/MRI plus either whole-body positron emission tomography [PET] or abdominal CT plus bone scan) are recommended. Involvement of mediastinal nodes and/or metastatic disease represents a contraindication to resection. **Grade of recommendation, 1C**
5. In patients with a potentially resectable, nonmetastatic Pancoast tumor (and good performance status), it is recommended that preoperative concurrent chemoradiotherapy be given before resection. **Grade of recommendation, 1B**
6. In patients who undergo resection of a Pancoast tumor, it is recommended that every effort be made to achieve a complete resection. **Grade of recommendation, 1A**
7. It is recommended that resection of a Pancoast tumor consist of a lobectomy (instead of a nonanatomic wedge resection) as well as the involved chest wall structures. **Grade of recommendation, 1C**
8. In patients with either a completely or incompletely resected Pancoast tumor, postoperative radiotherapy is not recommended because of lack of demonstrated survival benefit. **Grade of recommendation, 2C**
9. In patients who have an unresectable but nonmetastatic Pancoast tumor and good performance status, definitive concurrent chemotherapy and radiotherapy is recommended. **Grade of recommendation, 1C**
10. In patients who have Pancoast tumors and are not candidates for curative intent treatment, palliative radiotherapy is recommended. **Grade of recommendation, 1B**

T4N0, 1M0 Tumors

11. In patients who have a clinical T4N0,1M0 non-small cell lung cancer (NSCLC) and are being considered for curative resection, it is recommended that invasive mediastinal staging and extrathoracic imaging (head CT/MRI plus either whole-body PET or abdominal CT plus bone scan) be undertaken. Involvement of mediastinal nodes and/or metastatic disease represents a contraindication to resection. **Grade of recommendation, 1C**
12. In patients with a T4N0, 1M0 NSCLC, it is recommended that resection be undertaken only at a specialized center. **Grade of recommendation, 1C**

Satellite Nodules and Multiple Primary Lung Cancers (MPLCs)

Table: Definition of Satellite Nodules, MPLCs and Pulmonary Metastases

<p>Satellite nodules from primary tumor</p> <ul style="list-style-type: none"> • Same histology • And same lobe as primary cancer • And no systemic metastases
<p>Multiple primary lung cancers (MPLCs)</p> <ul style="list-style-type: none"> • Same histology, anatomically separated <ul style="list-style-type: none"> • Cancers in different lobes • And no N2, 3 involvement • And no systemic metastases • Same histology, temporally separated <ul style="list-style-type: none"> • ≥4-yr interval between cancers • And no systemic metastases from either cancer • Different histology <ul style="list-style-type: none"> • Different histologic type • Or different molecular genetic characteristics • Or arising separately from foci of carcinoma <i>in situ</i>
<p>Hematogenously spread pulmonary metastases</p> <ul style="list-style-type: none"> • Same histology and multiple systemic metastases • Same histology, in different lobes <ul style="list-style-type: none"> • And presence of N2,3 involvement • Or < 2-yr interval

Synchronous Nodules of Cancer in the Same Lobe

13. In patients with suspected or proven lung cancer and a satellite nodule within the same lobe, it is recommended that no further diagnostic workup of a satellite nodule be undertaken. **Grade of recommendation, 1B**
14. In patients with a satellite lesion within the same lobe as a suspected or proven primary lung cancer, evaluation of extrathoracic metastases and confirmation of the mediastinal node status should be performed as dictated by the primary lung cancer alone and not modified because of the presence of the satellite lesion. **Grade of recommendation, 1C**

15. In patients with NSCLC and a satellite focus of cancer within the same lobe (and no mediastinal or distant metastases), resection via a lobectomy is the recommended treatment. **Grade of recommendation, 1B**

Synchronous Second Primary Lung Cancer

Definition: A synchronous second focus of lung cancer in a different lobe is easily defined as a second primary lung cancer when the two sites are of different histologic types. One proposed requirement for classification as synchronous second primary lung cancers is that there be no mediastinal node involvement and no sites of distant metastases when the two cancers are of the same histologic type.

16. In patients who have two synchronous primary NSCLCs and are being considered for curative surgical resection, invasive mediastinal staging and extrathoracic imaging (head CT/MRI plus either whole-body PET or abdominal CT plus bone scan) are recommended. Involvement of mediastinal nodes and/or metastatic disease represents a contraindication to resection. **Grade of recommendation, 1C**
17. In patients suspected of having two synchronous primary NSCLCs, a thorough search for an extrathoracic primary cancer is recommended to rule out the possibility that both of the lung lesions represent metastases. **Grade of recommendation, 1C**
18. In patients (not suspected of having a second focus of cancer) who are found intraoperatively to have a second cancer in a different lobe, resection of each lesion is recommended, provided that the patient has adequate pulmonary reserve and there is no N2 nodal involvement. **Grade of recommendation, 1C**

Metachronous Second Primary Lung Cancer

Definition: A metachronous second focus of lung cancer is easily defined as a second primary lung cancer when the two tumors are of different histologic types. When they are of the same type, the second focus can be reliably defined as a second primary when there is no evidence of systemic metastases and at least a 4-year interval between the two.

19. In patients who have a metachronous NSCLC and are being considered for curative surgical resection, invasive mediastinal staging and extrathoracic imaging (head CT/MRI plus either whole-body PET or abdominal CT plus bone scan) are recommended. Involvement of mediastinal nodes and/or metastatic disease represents a contraindication to resection. **Grade of recommendation, 1C**

Isolated Brain Metastasis

20. In patients who have an isolated brain metastasis from NSCLC and are being considered for curative resection of a stage I or II lung primary tumor, invasive mediastinal staging and extrathoracic imaging (head CT/MRI plus either whole-body PET or abdominal CT plus bone scan) are recommended. Involvement of mediastinal nodes and/or metastatic disease represents a contraindication to resection. **Grade of recommendation, 1C**

21. In patients with no other sites of metastases and a synchronous resectable N0,1 primary NSCLC, resection or radiosurgical ablation of an isolated brain metastasis is recommended (as well as resection of the primary tumor).
Grade of recommendation, 1C
22. In patients with no other sites of metastases and a previously completely resected primary NSCLC (metachronous presentation), resection or radiosurgical ablation of an isolated brain metastasis are recommended.
Grade of recommendation, 1B
23. In patients who have undergone a curative resection of an isolated brain metastasis, adjuvant whole-brain radiotherapy (WBRT) is suggested, although there are conflicting and insufficient data regarding a benefit with respect to survival or the rate of recurrent brain metastases. **Grade of recommendation, 2B**
24. In patients who have undergone curative resections of both the isolated brain metastasis and the primary tumor, adjuvant chemotherapy may be considered. **Grade of recommendation, 2C**

Isolated Adrenal Metastasis

25. In patients who have an isolated adrenal metastasis from NSCLC and are being considered for curative intent surgical resection, invasive mediastinal staging and extrathoracic imaging (head CT/MRI plus either whole-body PET or abdominal CT plus bone scan) are recommended. Involvement of mediastinal nodes and/or metastatic disease represents a contraindication to resection. **Grade of recommendation, 1C**
26. In patients with a synchronous resectable N0,1 primary NSCLC and no other sites of metastases, resection of the primary tumor and an isolated adrenal metastasis is recommended. **Grade of recommendation, 1C**
27. In patients with no other sites of metastases and a previously completely resected primary NSCLC (metachronous presentation), resection of an isolated adrenal metastasis is the recommended treatment when the disease-free interval is > 6 months and complete resection of the primary NSCLC has been achieved. **Grade of recommendation, 1C**

Tumors That Invade the Chest Wall

28. In patients who have an NSCLC invading the chest wall and are being considered for curative intent surgical resection, invasive mediastinal staging and extrathoracic imaging (head CT/MRI plus either whole-body PET or abdominal CT plus bone scan) are recommended. Involvement of mediastinal nodes and/or metastatic disease represents a contraindication to resection, and definitive chemoradiotherapy is recommended for these patients. **Grade of recommendation, 2C**
29. At the time of resection of a tumor invading the chest wall, we recommend that every effort be made to achieve a complete resection. **Grade of recommendation, 1B**

Definitions:

Quality of Evidence Scale

High - Randomized controlled trials (RCTs) without important limitations or overwhelming evidence from observational studies*

Moderate - RCTs with important limitations (inconsistent results, methodologic flaws, indirect, or imprecise) or exceptionally strong evidence from observational studies*

Low or very low - Observational studies or case series

*Although the determination of magnitude of the effect based on observational studies is often a matter of judgment, the guideline developers offer the following suggested rule to assist this decision: a large effect would be a relative risk > 2 (risk ratio < 0.5) [which would justify moving from weak to moderate], and a very large effect is a relative risk > 5 (risk ratio < 0.2) [which would justify moving from weak to strong]. There is some theoretical justification in the statistical literature for these thresholds (the magnitude of effect that is unlikely or very unlikely to be due to residual confounding after adjusted analysis). However, once the decision is made, authors should be explicit in justifying their decisions.

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Moderate	1B	1B	2B	
Low or very low	1C	1C	2C	2C

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate diagnosis and management of patients with lung cancers that require special treatment considerations

POTENTIAL HARMS

Surgical resections carry the risk of operative mortality.

CONTRAINDICATIONS

CONTRAINDICATIONS

- N2,3 lymph node involvement in patients with Pancoast tumors is a major negative prognostic factor and should generally be considered a contraindication to surgery.
- Involvement of mediastinal nodes and/or metastatic disease represents a contraindication to surgical resection.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The publication of the *Diagnosis and Management of Lung Cancer: ACCP Evidence-Based Clinical Practice Guidelines; Second Edition* in *CHEST* is the first of two dissemination vehicles. The circulation of the journal is 23,000 subscribers and libraries, including six translations and distribution to 107 countries. All subscribers received a copy of this full-text guideline. The American College of Chest Physicians (ACCP) Clinical Resource on Lung Cancer is composed of a printed publication and an accompanying CD-ROM, containing a quick reference guide for physicians and other health-care providers, patient-targeted educational materials, and a set of slides for use in educational or clinical contexts. In addition, the recommendations and grading are personal digital assistant downloadable from the clinical resource. This product is available for purchase from the ACCP. The patient education materials are accessible free of charge on www.chestnet.org.

The implementation and translation of evidence-based clinical practice guidelines facilitates knowledge uptake, critical for practice change, and should ultimately lead to better patient-focused care. The HSP Subcommittee on Implementation has proposed to collaborate with the Governors, Thoracic Oncology Network, and other groups within the ACCP to disseminate and implement the guidelines in their local communities. Residency and specialty training programs are encouraged to use the guidelines in journal clubs and grand rounds. Other organizations that were invited to send representatives to the final conference and review the

proposed drafts were also requested to endorse the guidelines and market them to their membership through their own communication channels.

IMPLEMENTATION TOOLS

Patient Resources
Resources

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

End of Life Care
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Shen KR, Meyers BF, Larner JM, Jones DR, American College of Chest Physicians. Special treatment issues in lung cancer: ACCP evidence-based clinical practice guidelines (2nd edition). Chest 2007 Sep;132(3 Suppl):290S-305S. [79 references] [PubMed](#)

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2003 Jan (revised 2007 Sep)

GUIDELINE DEVELOPER(S)

American College of Chest Physicians - Medical Specialty Society

SOURCE(S) OF FUNDING

American College of Chest Physicians

GUIDELINE COMMITTEE

American College of Chest Physicians (ACCP) Expert Panel on Lung Cancer Guidelines

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Primary Authors: K. Robert Shen, MD; Bryan F. Meyers, MD, FCCP; James M. Lerner, MD; David R. Jones, MD, FCCP

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Funding for both the evidence review and guideline development was supported by educational grants from AstraZeneca LP, Bristol-Myers Squibb Company, Eli Lilly and Company, Genentech, and Sanofi-Aventis. Representatives from these companies were neither granted the right of review, nor were they allowed participation in any portion of the guideline development process. This precluded participation in either conference calls or conferences. No panel members or ACCP reviewers were paid any honoraria for their participation in the development and review of these guidelines.

The ACCP approach to the issue of potential or perceived conflicts of interest established clear firewalls to ensure that the guideline development process was not influenced by industry sources. This policy is published on the ACCP Web site at www.chestnet.org. All conflicts of interest within the preceding 5 years were required to be disclosed by all panelists, including those who did not have writing responsibilities, at all face-to-face meetings, the final conference, and prior to submission for publication. The most recent of these conflict of interests are documented in this guideline Supplement. Furthermore, the panel was instructed in this matter, verbally and in writing, prior to the deliberations of the final conference. Any disclosed memberships on speaker's bureaus, consultant fees, grants and other research monies, and any fiduciary responsibilities to industry were provided to the full panel in writing at the beginning of the conference and at submission for publication.

ENDORSER(S)

American Association for Bronchology - Disease Specific Society
American Association for Thoracic Surgery - Medical Specialty Society
American College of Surgeons - Medical Specialty Society
American Society for Therapeutic Radiology and Oncology
Asian Pacific Society of Respiriology - Disease Specific Society
Oncology Nursing Society - Professional Association
Society of Thoracic Surgeons - Medical Specialty Society
World Association of Bronchology - Disease Specific Society

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Detterbeck FC, Jones DR, Kernstine KH, Naunheim KS. Presentations of lung cancer with special treatment considerations. Chest 2003 Jan;123(1 Suppl):244S-58S.

GUIDELINE AVAILABILITY

Electronic copies: Available to subscribers of [Chest - The Cardiopulmonary and Critical Care Journal](#).

Print copies: Available from the American College of Chest Physicians, Products and Registration Division, 3300 Dundee Road, Northbrook IL 60062-2348.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

Executive Summary:

- Alberts MW. Diagnosis and management of lung cancer executive summary. Chest 2007 Sep;132(3 Suppl):1S-19.

Background Articles:

- Alberts WM. Introduction: diagnosis and management of lung cancer. Chest 2007 Sep;132(3 Suppl):20S-22.
- McCrory DC, Lewis SZ, Heitzer J, Colice GL, Alberts WM. Methodology for lung cancer evidence review and guideline development. Chest 2007 Sep;132(3 Suppl):23S-28.
- Alberg AJ, Ford JG, Samet JM. Epidemiology of lung cancer. Chest 2007 Sep;132(3 Suppl):29S-55.

Electronic copies: Available to subscribers of [Chest - The Cardiopulmonary and Critical Care Journal](#).

Print copies: Available from the American College of Chest Physicians, Products and Registration Division, 3300 Dundee Road, Northbrook IL 60062-2348.

The following is also available:

- ACCP clinical resources: Diagnosis and management of lung cancer: ACCP evidence-based clinical practice guidelines (2nd edition).

Available from the [American College of Chest Physicians Web site](#).

PATIENT RESOURCES

The following are available:

- Lung cancer guides: lung cancer...am I at risk? Patient education guide. Northbrook (IL): American College of Chest Physicians, 2004. 12 p.

- Lung cancer guides: What if I have a spot on my lung? Do I have cancer? Patient education guide. Northbrook (IL): American College of Chest Physicians, 2004. 16 p.
- Lung cancer guides: living with lung cancer. Patient education guide. Northbrook (IL): American College of Chest Physicians, 2004. 12 p.
- Lung cancer guides: advanced lung cancer: issues to consider. Patient education guide. Northbrook (IL): American College of Chest Physicians, 2004. 12 p.

Electronic copies: Available in Portable Document Format (PDF) from the [American College of Chest Physicians \(ACCP\) Web site](#).

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

This NGC summary was completed by ECRI on September 3, 2003. The information was verified by the guideline developer on October 1, 2003. This NGC summary was updated by ECRI Institute on November 28, 2007. The updated information was verified by the guideline developer on December 21, 2007.

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